Alberta Office of the Superintendent of Insurance

Diagnostic Treatment Protocols Regulation Interpretative Guide

Last updated: August 23, 2018

Alberta Treasury Board and Finance
Superintendent of Insurance
Financial Sector Regulation and Policy (FSRP)
Room 402, Terrace Building
9515 - 107 Street
Edmonton, Alberta, T5K 2C3
Phone 780-427-8322 • Fax 780-420-0752
For toll-free service in Alberta, call 310-0000, then enter the number.

Table of Contents

Section 1

General Information

Introduction

Alberta Treasury Board and Finance is tasked with regularly reviewing Alberta's automobile insurance regulations, including the Minor Injury Regulation (MIR) and the Diagnostic Treatment Protocols Regulation (DTPR).

The over-riding objective of the DTPR is to ensure that people who are injured in collisions receive fast and effective treatment to support their recovery. The DTPR is the result of an extensive review of the processes and requirements related to treatment and claims for related injuries. Prior to the introduction of the DTPR in 2004, individuals who were injured in a motor vehicle collision were required for their treatment and/or rehabilitation out-of-pocket and insurers were not required to permit direct billing. This process often caused delays and disagreements regarding the type and extent of treatment required.

Early diagnosis and treatment is known to speed up recovery and help individuals return to work and their normal activities. This process is designed to:

- Ensure that individuals with minor injuries do not have to wait for approval from their insurance company before treatment begins;
- Use the best available evidence to guide diagnosis and treatment; and
- Provide an effective process for treating people with DTPR injuries while, at the same time, providing a second opinion for individuals who are not recovering as expected.

This guide provides information for insurers, lawyers, and primary health care practitioners (physicians, chiropractors, and physical therapists). The guide includes information about the DTPR and how it should be applied, as well as the claims and billing processes.

Scope of the Diagnosis and Treatment Protocols

The DTPR was developed in consultation with primary health care practitioners and are based on the best available research and evidence. The DTPR applies specifically to the following types of injuries: sprains, strains, whiplash-associated disorders (WAD), some temporomandibular joint (TMJ) injuries, and related physical or psychological symptoms. Other injuries such as fractures, internal injury, etc. are excluded from the DTPR.

The DTPR is intended to streamline the process for both patients and primary health care practitioners. Under the DTPR, primary health care practitioners do not have to seek approval from the insurer to treat minor injuries and receive payment, although they are required to notify the insurer of the claim. Primary health care practitioners will then be able to bill the auto insurer directly for all treatment services outlined in the DTPR, unless covered by Alberta Health Care Insurance.

Although the DTPR specifically outlines the types of treatments recommended for strains, sprains and WAD injuries, specific limits are placed on the number of visits and treatments required. At the same time, if the primary health care practitioner is uncertain about the nature of the injury, or believes that the injury is not resolving appropriately or within the expected timelines, they can refer the patient to an Injury Management Consultant (IMC). The injury management consultant can:

- Provide advice;
- Report on the diagnosis and treatment of the patient; and
- Recommend a further assessment or multidisciplinary assessment of the injury.

It is important to note that the DTPR sets out a general approach to the treatment of minor injuries associated with motor vehicle collisions. The DTPR does not prevent or limit a patient or a primary health care practitioner from asking an insurer to authorize investigations or treatments beyond the specified limits.

Section 2

Definitions

The following definitions reflect the wording found in MIR and are for the purposes of the Guide:

- **Evidence-based medicine** - means the conscientious, explicit and judicious use of current best practice in making decisions about the care of a patient, integrating individual clinical expertise with the best available external clinical evidence from systematic research.

- **Injury Management Consultant (IMC)** - means a primary health care practitioner (medical doctor, chiropractor, or physical therapist) who is entered on the Injury Management Consultant register (IMC Register). The IMC register can be found on the Government of Alberta website at: http://insurance.alberta.ca.

- **Passive modalities of care**- implies that the patient is passive rather than active in the medical encounter. This may include the use of painkillers, injections or surgery by physicians, chiropractic manipulation, heat and cold therapy, transcutaneous electrical nerve stimulation, sonic treatment, infrared applications, massage therapy, etc.

- **Related physical or psychological symptoms** – means physical or psychological conditions or symptoms arising from sprains, strains and whiplash injuries and that resolve with those injuries.

- **Spine** - the column of bone known as the vertebral column that surrounds and protects the spinal cord. This includes all areas of the spine, not the cervical spine only.

- **Strain** - means an injury to one or more muscles.

- **Sprain** - means an injury to one or more of the tendons or ligaments, or to both.

- **Temporomandibular joint injury (TMJ injury)** – means an injury to the temporomandibular joint that does not result in damage to the teeth, bones, or cartilage.

- **Whiplash-associated disorder injury (WAD injury)** - means a whiplash associated disorder other than one that exhibits one or both of the following:

    - Objective, demonstrable, definable and clinically relevant neurological signs;

    - A fracture to or a dislocation of the spine.

Claims and Billing

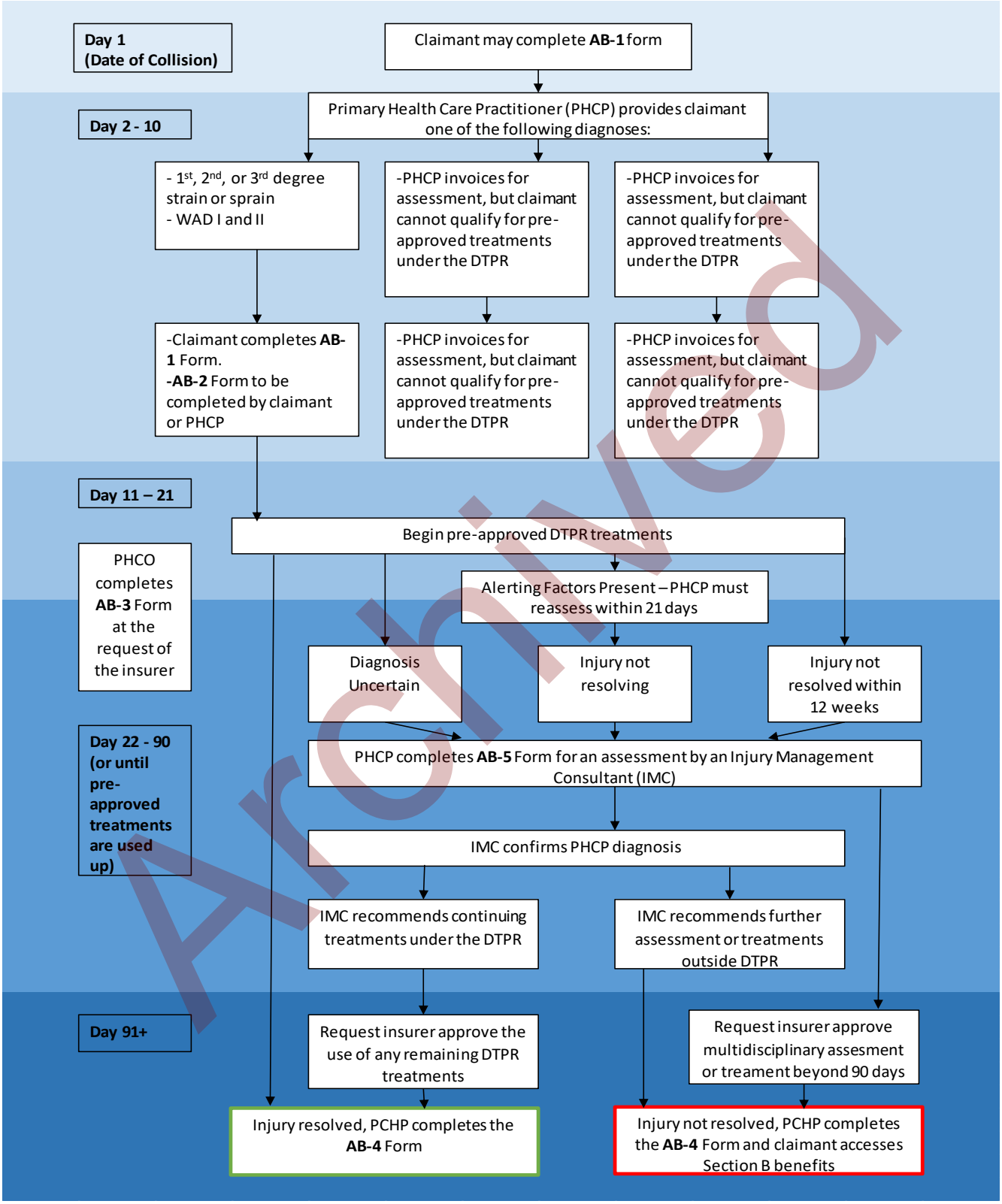
Appendix G outlines how the claims and billing process functions, important timelines, and when primary health care practitioners need to use prescribed forms.

The objective of the claims process is to provide a straightforward, step-by-step procedure that ensures continuity of care for patients, as well as appropriate payment for the services provided.

Several key points include:

- Payment for services provided under the DTPR by insurers will be within 30 days of receipt of the invoice.
- Payment for completion of a prescribed form may not be honored if documents are incomplete or illegible.
- Practitioners must have an internal administrative process to verify the services provided to patients.
- When generating the final invoice to the insurer, a copy of the invoice shall be mailed to the patient with a standard letter that indicates the following: "your insurer has been billed in the amounts shown for all goods and services listed. Please review the invoice and report any errors to the signatory or your insurer."
- If a patient misses an appointment or is late for an appointment, the insurer is not responsible for reimbursing the primary health care practitioner for that time. The primary health care practitioner may charge the patient a late or missed appointment fee.
- The DTPR is intended to cover services provided by primary health care practitioner(s) (defined as physicians, physical therapists and chiropractors) and adjunct therapy practitioners (massage therapists and acupuncturists). The provision of other services listed under, Section B of the Automobile Accident Insurance Benefits Regulation (such as dental services, psychological services, occupational therapy, etc.) is permitted to occur simultaneously. The provision of these services does not cancel preauthorization of DTPR treatments.
- Adjunct therapies will only be preauthorized when directed by the primary health care practitioners and is documented on the Treatment Plan form (AB-2). Where adjunct therapies do not need to be preauthorized, this does not prevent patients from obtaining these services under the Section B rules.
- If you are having trouble locating or contacting the claims adjuster for your patient please contact the insurer's claims manager, the insurer's ombudspersons or the General Insurance Ombudservice (GIO).A list of insurer ombudspersons can be found on the Government of Alberta website at: http://insurance.alberta.ca. You may also contact the Insurance Bureau of Canada by phone 1-800-377-6378 or through the website at http://www.ibc.ca/ab/.
- To receive updates on fees, form amendments, and related issues a subscription service is available on the Government of Alberta website at http://insurance.alberta.ca.

- Information collected through the claims process is important, not only to process claims, but also to track outcomes for patients and the effectiveness of the DTPR. Primary health care practitioners will be compensated for providing services under the DTPR and completing the prescribed forms (further details can be found at: http://insurance.alberta.ca).


Day 1
(Date of Collision)
Claimant may complete AB-1 form
Day 2 - 10
Primary Health Care Practitioner (PHCP) provides claimant one of the following diagnoses:
- 1st, 2nd, or 3rd degree strain or sprain
- WAD I and II
-PHCP invoices for assessment, but claimant cannot qualify for pre-approved treatments under the DTPR
-PHCP invoices for assessment, but claimant cannot qualify for pre-approved treatments under the DTPR
-Claimant completes AB-1 Form.
-AB-2 Form to be completed by claimant or PHCP
-PHCP invoices for assessment, but claimant cannot qualify for pre-approved treatments under the DTPR
-PHCP invoices for assessment, but claimant cannot qualify for pre-approved treatments under the DTPR
Day 11 – 21
Begin pre-approved DTPR treatments
PHCO completes AB-3 Form at the request of the insurer
Alerting Factors Present – PHCP must reassess within 21 days
Diagnosis Uncertain
Injury not resolving
Injury not resolved within 12 weeks
Day 22 - 90 (or until pre-approved treatments are used up)
PHCP completes AB-5 Form for an assessment by an Injury Management Consultant (IMC)
IMC confirms PHCP diagnosis
IMC recommends continuing treatments under the DTPR
IMC recommends further assessment or treatments outside DTPR
Day 91+
Request insurer approve the use of any remaining DTPR treatments
Request insurer approve multidisciplinary assesment or treament beyond 90 days
Injury resolved, PCHP completes the AB-4 Form
Injury not resolved, PCHP completes the AB-4 Form and claimant accesses Section B benefits

Privacy Statement

For Health Care Practitioners

The Alberta Accident Benefits Claims Forms has been developed taking into account the limits on personal information collection, use and disclosure in relevant federal and provincial privacy legislation (i.e. HIA, PIPA, PIPEDA and FOIPP).

Relevant and necessary information about your patients will not be collected, used or disclosed without the individual's consent, although statistical information concerning these individuals will be provided to the Insurance Bureau of Canada for analysis and further dissemination. The business contact information you provide as a primary health care practitioner will be used to facilitate communication with you as necessary.

For More Information

Additional information is also available at: http://insurance.alberta.ca. The web site provides further information on diagnosis and treatment of DTPR related injuries, patient and claims information, as well as related documents.

If you have questions about any aspect of this guide or the diagnostic and treatment DTPR, please contact the Office of the Superintend of Insurance by email, mail, phone or fax:

Email: tbf.insurance@gov.ab.ca

Mail:
Alberta Treasury Board and Finance
Superintendent of Insurance
Financial Sector Regulation and Policy (FSRP)
Room, 402, Terrace Building
9515 – 107 Street
Edmonton, Alberta T5K 2C3

Phone:
Office of the Superintendent of Insurance Main Line: 780-427-8322
Insurance Regulation and Market Conduct Branch: 780-643-2237

Toll-Free: (From anywhere in Alberta): Dial 310, 0000, then the number (including area code).

Fax: 780-420-0752

Sprains and Strains

Diagnosis

With reference to the International Classification of Diseases and using evidence informed medicine, a diagnosis of a strain or sprain is to be established by a primary health care practitioner using the following process:

1. Taking a history of the patient- collect the patient's history including the mechanism of injury, the current symptoms the patient is experiencing, the patient's relevant past history, including physical, psychological, emotional, cognitive and social history and how the patient's physical functions have been affected by the injury.

2. Examining the patient- conduct a general examination, a relevant regional examination, including an examination of the neurological and musculoskeletal system and an assessment of the pain associated with the injury.

3. Making an ancillary investigation and conduct and/or review the findings from any ancillary investigation including, as required, diagnostic imaging, laboratory testing, and specialized testing.

4. Identify as best as possible the muscle(s), ligament(s) or tendon(s) injured if a sprain or strain is diagnosed, and assess the degree of the strain or sprain (see **Appendices A and B** for further guidance).

    a. The muscle or muscle groups injured; or

    b. The tendons or ligaments, or both, that are involved and the specific anatomical site of the injury.

5. Reference the ICD-10-CA Handbook to include a diagnostic code where possible (See **Appendix F**).

Treatment

1. Educate the patient with respect to the following matters:

   a. The desirability of an early return to normal activities and to work, if applicable;

   b. An estimate of the probable length of time that symptoms will last; and

   c. The normalcy of physical and psychological symptoms and conditions that present alongside a sprain, strain, WAD, or TMJ injury and resolve with those injuries.

2. Manage inflammation and pain as required.

3. Teach the patient about maintaining flexibility, balance, strength and the functions of the injured area.

4. Advise the patient about self-care and the disadvantage of extended dependence on primary health care providers. This encourages an active modality of care.

5. Provide other adjunct therapy that, in your opinion, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the patient.

6. Treatments that are authorized for payment and do not require prior approval from the insurer include:

   a. Necessary diagnostic imaging, laboratory testing and specialized testing;

   b. Necessary medication to manage the pain;

   c. Acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury;

   d. For a 1st or 2nd degree strain/sprain, not more than a combined total of 10 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment; and

   e. For a 3rd degree strain/sprain, a combined total of 21 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment.

Whiplash-Associated Disorders (WAD) Injuries

General Diagnosis

According to the *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders: Redefining "Whiplash" and Its Management*, published by Hagerstown, MD: J.B. Lippincott Company, 1995, and using evidence based medicine, a diagnosis of a WAD injury is to be established by a primary health care practitioner using the following process:

Taking a history of the patient, including:

- How the injury occurred;
- The current symptoms the patient is experiencing;
- The patient's relevant past history, including physical, psychological, emotional and social history;
- Inquiry into alerting factors that may influence prognosis; and
- How the patient's physical functions have been affected by the injury.

Examining the patient:

- Conduct a general examination, a relevant regional examination, including an examination of the neurological and musculoskeletal system and an assessment of the pain associated with the injury.
- For determining the grade of the WAD injury, the Canadian C-spine rule is used. See Appendix C for criteria for grading and diagnosing WAD injuries and Appendix D for further information about the Canadian C-Spine Rule.
- If a WAD I injury is diagnosed, no further investigation of the injury is warranted, unless there is specific cause cited to do so.
- An investigation to determine a WAD II injury and to rule out a more severe whiplash injury may include:
- Making an ancillary investigation:
    - Conduct and/or review the findings from any ancillary investigation including, as required, diagnostic imaging, laboratory testing, and specialized testing.

Treatment

1. Educate the patient about at least the following matters:

    a. The desirability of an early return to normal activities and to work. If applicable an estimate of the probable length of time that symptoms will last;

    b. Reassurance that there is likely no serious currently detectable underlying cause of the pain, if applicable;

    c. The importance of postural and body mechanics control;

    d. The use of a soft collar is not advised; and

    e. Probable factors that are responsible for other symptoms the patient may be experiencing, including disturbance of balance, disturbance or loss of hearing, limb pain or numbness, cognitive dysfunction and jaw pain. The patient should be advised that these symptoms are temporary in nature and may not reflect tissue damage, if so determined.

2. Manage pain as required.

3. Teach the patient about maintaining flexibility, balance, strength and the functions of the injured area.

4. Provide advice about self-management and the disadvantage of extended dependence on primary health care providers.

5. Prevent dependence on passive modalities of care. It is the role of the primary health care practitioner to educate patients on the disadvantages of developing a dependence solely on passive modalities of care. Although passive treatment is valuable, active participation from the patient is often required for optimal recovery.

6. Provide other adjunct therapy that, in your opinion, is necessary for the treatment or rehabilitation of the injury and is linked to the continued clinical improvement of the patient.

7. Treatments that are authorized for payment and do not require prior approval from the insurer include:

    a. For a WAD I or II injury, one visit to a primary health care practitioner for an assessment of the injury, including the preparation of a treatment plan and a prescribed claim form, if required. This visit is in addition to the visits for treatment indicated below;

    b. Necessary diagnostic imaging, laboratory testing and specialized testing;

    c. Necessary medication to manage the pain;

    d. Acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury;

e. For a WAD I injury, not more than a combined total of 10 medical, physical therapy, chiropractic, and adjunct therapy visits. For treatment for a WAD II injury, not more than a combined total of 21 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment; and

f. Though the treatment of WAD III or WAD IV injuries are not authorized under the DTPR, until an assessment under (and covered by) the DTPR is completed, the patient and injury remain within its scope. The assessment fee shall be covered by the insurer and the fee payable shall be in accordance with the applicable Notice of Fees and Disbursements (further details can be found at: http://insurance.alberta.ca).

8. Identify alerting factors.

a. If a patient is diagnosed with a WAD I or WAD II injury and the patient has any alerting characteristics that may influence prognosis (see **Appendix E**), the primary health care practitioner must seek to reassess the patient within 21 days of the collision and, if the injury is not resolving, refer the patient to an IMC for an assessment and report.

Section 4

Referral to an Injury Management Consultant (IMC)

A primary health care practitioner may refer the patient to an IMC if the primary health care practitioner:

1. Is uncertain about an injury to which the DTPR apply or the diagnosis/ treatment of the injury.
2. Believes that the injury:
    a. Is not resolving appropriately; or
    b. Is not resolving within the time expected and the practitioner requires another opinion.

The DTPR aims to confirm the initial diagnosis early on, and if the patient is not responding to the treatment, then the patient should be moved to an interdisciplinary assessment from an IMC.

The IMC will:

1. Review all relevant information regarding the injury.
2. Examine the patient/patient with reference to the diagnosis and treatment DTPR.
3. Provide advice and a report about the diagnosis or treatment of the patient/patient; or
4. Recommend a further assessment or a multi-disciplinary assessment of the injury or an aspect of the injury and the persons who should be included in that assessment.

Appendix A — Degrees of Strain

	1st degree strain	2nd degree strain	3rd degree strain
Definition of the degree of strain	Few fibres of muscle torn	About half of muscle fibres torn	All muscle fibres torn (rupture)
Mechanism of injury	Overstretch Overload	Overstretch Overload Crushing	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Moderate to major (reflex inhibition)	Moderate to major
Disability	Minor	Moderate	Major
Muscle spasm	Minor	Moderate to major	Moderate
Swelling	Minor	Moderate to major	Moderate to major
Loss of function	Minor	Moderate to major	Major (reflex inhibition)
Pain on isometric	Minor	Moderate to major	None to minor
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal
Palpable defect	No	No	Yes (if detected early)
Range of motion	Decreased	Decreased	May increase or decrease depending on swelling

Extracted from Orthopaedic Physical Assessment by David J. Magee, (6th), (2013), pg 32, with permission from Elsevier Inc.

Appendix B — Degrees of Sprain

	1st degree sprain	2nd degree sprain	3rd degree sprain
Definition of the degree of sprain	Few fibres of ligament torn (partial tear, no instability or opening of the joint)	About half of ligament torn (partial tear with some instability indicated by partial opening of the joint on stress manoeuvres)	All fibres of ligament torn (complete tear with complete opening of the joint on stress manoeuvres)
Mechanism of injury	Overstretch Overload	Overstretch Overload	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Minor to moderate	Minor to moderate
Disability	Minor	Moderate	Moderate to major
Muscle spasm	Minor	Minor	Minor
Swelling	Minor	Moderate	Moderate to major
Loss of function	Minor	Moderate to major	Moderate to major (instability)
Pain on isometric contraction	None	None	None
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal to excessive
Palpable defect	No	No	Yes (if detected
Range of Motion	Decreased	Decreased	May increase or decrease depending on swelling. Dislocation

Extracted from Orthopaedic Physical Assessment by David J. Magee, (6th), (2013), pg 32, with permission from Elsevier Inc.

Appendix C — Grading and Diagnosis of Whiplash Associated Disorders (WAD)

1. WAD I criteria:

   - Symptoms of spinal pain, stiffness or tenderness;
   - No demonstrable, definable and clinically relevant physical signs of injury;
   - No tenderness and normal range of motion;
   - Normal reflexes and muscle strength in the limbs;
   - No objective, demonstrable, definable and clinically relevant neurological signs of injury; and
   - No fractures to or dislocation of the spine.

2. WAD II criteria:

   - Symptoms of spinal pain, stiffness or tenderness;
   - Musculoskeletal signs of decreased range of motion of the spine, and point tenderness of spinal structures affected by the injury;
   - Paraspinal tenderness and restricted spine range of motion;
   - Normal reflexes and muscle strength in the limbs;
   - No objective, demonstrable, definable and clinically relevant neurological signs of injury; and
   - No fracture to or dislocation of the spine.

3. WAD III criteria:

   - Objective, demonstrable, definable and clinically relevant neurological signs of injury;
   - Abnormal reflexes and/or muscle weakness, often with sensory changes in a dermatomal pattern suggesting nerve root impingement (typically due to disc protrusion); and
   - No fracture to or dislocation of the spine.

4. WAD IV criteria:

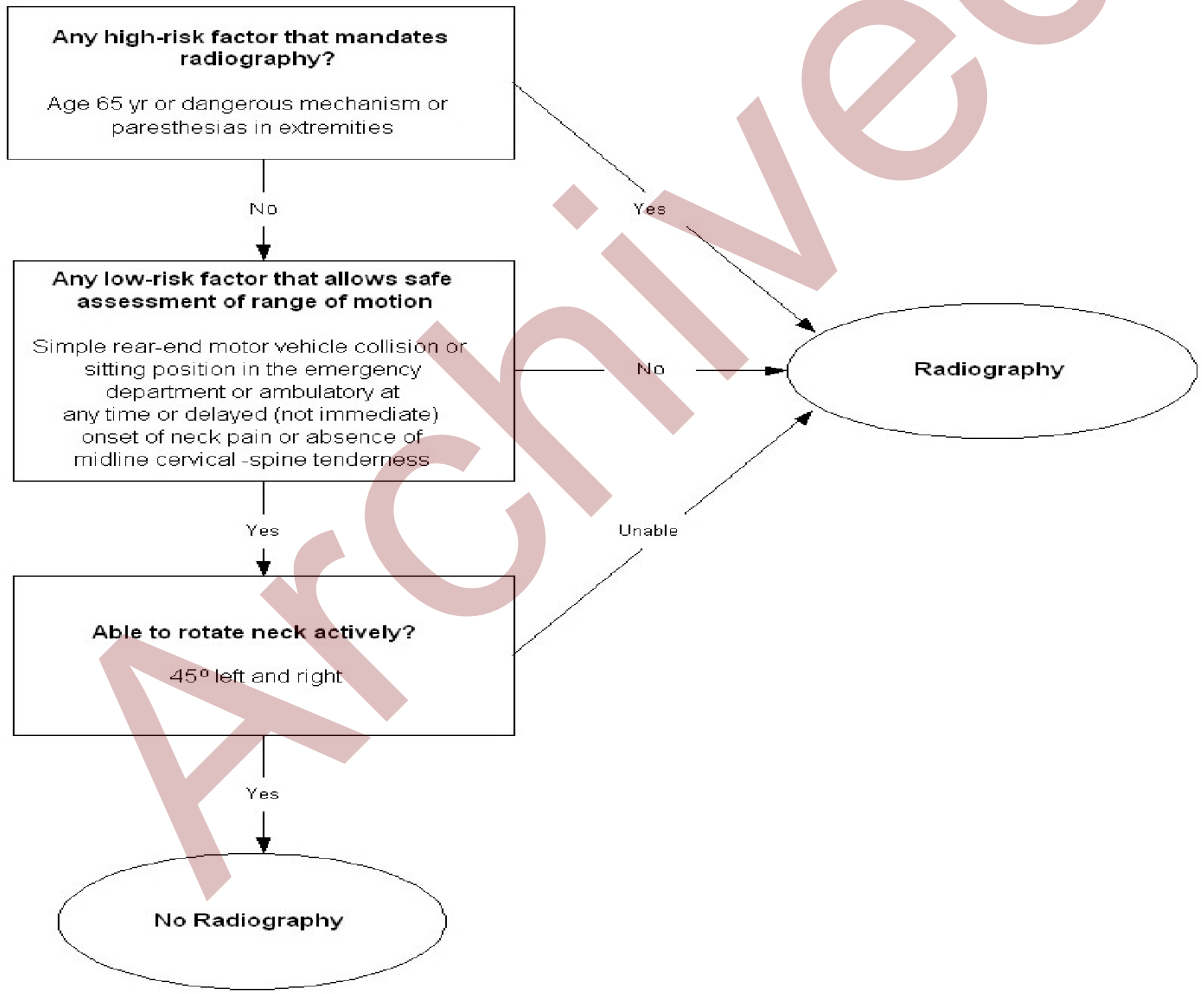
   - Fracture to or dislocation of the spine;
   - Neck pain, possibly neurological symptoms in limbs, urinary incontinence due to spinal cord involvement; and

- Possible hyperreflexia, positive Babinski's sign, motor weakness and sensory changes suggesting spinal cord injury.

* All terms are made with reference to the *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders: Redefining "Whiplash" and Its Management*, published by Hagerstown, MD: J.B. Lippincott Company, 1995 and the DTPR, where appropriate.

Appendix D — Canadian C-Spine Rule

"For patients with trauma who are alert (as indicated by the score of 15 on the Glasgow Coma Scale) and in stable condition and in who cervical-spine injury is a concern, the determination of risk factors guides the use of cervical-spine radiography. A dangerous mechanism is considered to be a fall from an elevation of > three feet or five stairs; an axial load to the head (e.g., diving); a motor vehicle collision at high speed (greater than 100 km/hr) or with rollover or ejection; a collision involving a motorized recreational vehicle; or a bicycle collision. A simple rear-end motor collision excludes being pushed into oncoming traffic, being hit by a bus or a large truck, a rollover, and being hit by a high-speed vehicle." (Excerpted from *The Canadian C-Spine Rule for Radiography in Alert and Stable Trauma Patients,* published in the *Journal of the American Medical Association*, October 17, 2001 – Volume 286, No. 15.)



Appendix E — Alerting Factors

If a patient is diagnosed with a WAD I or WAD II injury and the patient has any alerting characteristics that may influence prognosis (see below), the primary health care practitioner must seek to reassess the patient within 21 days of the collision and, if the injury is not resolving, refer the patient to an IMC for an assessment and report.

Alerting factors for Grade I and II WAD (factors repeatedly shown to be associated with delayed healing) include:

- Age greater than 40;
- Female;
- More intense baseline neck or back pain;
- More intense baseline headache;
- The presence of baseline radicular symptoms; and
- The presence of depressive or other significant emotional distress symptoms within the early weeks.

Appendix F — International Classification of Disease (ICD-10-CA) Handbook

What is ICD-10?

The *International Statistical Classification of Diseases and Related Health Problems - Tenth Revision* is the most recent revision of an international core classification of diseases, injuries, and causes of death. The *World Health Organization* (WHO) is responsible for maintaining and revising ICD-10. Over time, the use of ICD has expanded. It is now used by many countries in hospitals, doctors' offices and health care facilities to record non-fatal diseases, symptoms and other conditions necessitating contact with health care providers for medical services.

What is ICD-10-CA?

With the approval of Health Canada, the Canadian Institute for Health Information (CIHI) has received permission to enhance the international classification to meet Canadian needs within the requirements of its licence agreement with WHO.

ICD-10-CA Code List

The following list is a sub-set of ICD-10-CA (2003) codes. **It neither endorses nor precludes the use of any ICD-10-CA code.** Codes should be selected based upon the guidance from provider associations, the appropriateness of a specific code for a particular clinical situation, and guidelines provided by the Canadian Institute for Health Information.

The ICD-10-CA Injury Codes are only required for the completion of the Notice of Loss and Proof of Claim Form (Form AB-1) and the Treatment Plan (Form AB-2) for Sprains and Strains. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

If you require further assistance, please contact the Senior Medical Advisor to the Superintendent of Insurance at tbf.insurance@gov.ab.ca.

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF HEAD

CODE	INJURY DESCRIPTION
S03.0	Dislocation of jaw
S03.3	Dislocation of other and unspecified parts of head
S03.4	Sprain and strain of jaw
S03.5	Sprain and strain of joints and ligaments of other and unspecified parts of head

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS AT NECK LEVEL

CODE	INJURY DESCRIPTION
S13.1	Dislocation of cervical vertebra
S13.2	Dislocation of other and unspecified parts of neck
S13.3	Multiple dislocations of neck
S13.40	Whiplash Associated Disorder (WAD I) with complaint of neck pain, stiffness or tenderness (No Physical Signs, whiplash not otherwise specified)
S13.41	Whiplash Associated Disorder (WAD II) with complaint of neck pain with musculoskeletal signs (decreased ranged of motion and point tenderness)
S13.42	Whiplash Associated Disorder (WAD III) with complaint of neck pain with neurological signs (decreased or absent deep tendon reflexes, weakness and sensory deficits)
S13.48	Other sprain and strain of cervical spine
S13.5	Sprain and strain of thyroid region
S13.6	Sprain and strain of joints and ligaments of other and unspecified parts of neck

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF THORAX

CODE	INJURY DESCRIPTION
S23.0	Traumatic rupture of thoracic intervertebral disc
S23.1	Dislocation of thoracic vertebra
S23.2	Dislocation of other and unspecified parts of thorax
S23.3	Sprain and strain of thoracic spine (WAD I or II)
S23.4	Sprain and strain of ribs and sternum
S23.5	Sprain and strain of other and unspecified parts of thorax

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF LUMBAR SPINE AND PELVIS

CODE	INJURY DESCRIPTION
S33.0	Traumatic rupture of lumbar intervertebral disc
S33.1	Dislocation of lumbar vertebra
S33.2	Dislocation of sacroiliac and sacrococcygeal joint
S33.3	Dislocation of other and unspecified parts of lumbar spine and pelvis
S33.4	Traumatic rupture of symphysis pubis
S33.5	Sprain and strain of lumbar spine (WAD I or II)
S33.6	Sprain and strain of sacroiliac joint
S33.7	Sprain and strain of other and unspecified parts of lumbar spine and pelvis

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF SHOULDER GIRDLE

CODE	INJURY DESCRIPTION
S43.00	Anterior dislocation of shoulder
S43.01	Posterior dislocation of humerus
S43.02	Inferior dislocation of humerus
S43.09	Unspecified dislocation of glenohumeral joint
S43.1	Dislocation of acromioclavicular joint
S43.2	Dislocation of sternoclavicular joint
43.38	Dislocation of other parts of shoulder girdle
S43.39	Dislocation of unspecified part of shoulder girdle
S43.400	Sprain and strain of shoulder joint, coracohumeral joint
S43.401	Sprain and strain of shoulder joint, rotator cuff (capsule)
S43.5	Sprain and strain of acromioclavicular joint
S43.6	Sprain and strain of sternoclavicular joint
S43.70	Sprain and strain of other and unspecified parts of shoulder girdle, coracoclavicular joint (ligament)
S43.71	Sprain and strain of other and unspecified parts of shoulder girdle, Infraspinatus (muscle) (tendon)
S43.72	Sprain and strain of other and unspecified parts of shoulder girdle, subscapularis (muscle)
S43.73	Sprain and strain of other and unspecified parts of shoulder girdle, supraspinatus (muscle)
S43.78	Sprain and strain of other parts of shoulder girdle
S43.79	Sprain and strain of unspecified part of shoulder girdle

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF ELBOW

CODE	INJURY DESCRIPTION
S53.0	Dislocation of radial head
S53.10	Anterior dislocation of elbow
S53.11	Posterior dislocation of elbow
S53.12	Medial dislocation of elbow
S53.13	Lateral dislocation of elbow
S53.18	Other dislocation of elbow
S53.19	Unspecified dislocation of elbow
S53.2	Traumatic rupture of radial collateral ligament
S53.3	Traumatic rupture of ulnar collateral ligament
S53.40	Sprain and strain of radial collateral ligament
S53.41	Sprain and strain of ulnar collateral ligament
S53.42	Sprain and strain of radiohumeral (joint)
S53.43	Sprain and strain of ulnohumeral (joint)
S53.48	Other sprain and strain of elbow
S53.49	Unspecified sprain and strain of elbow

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS AT WRIST AND HAND LEVEL

CODE	INJURY DESCRIPTION
S63.00	Dislocation of radioulnar (joint) distal
S63.01	Dislocation of radiocarpal (joint)
S63.02	Dislocation of midcarpal (joint)
S63.03	Dislocation of carpometacarpal (joint)
S63.04	Dislocation of metacarpal (bone) proximal end
S63.08	Other dislocation of wrist
S63.09	Unspecified dislocation of wrist
S63.10	Dislocation of metacarpophalangeal (joint) of finger
S63.11	Dislocation of interphalangeal (joint) of finger
S63.18	Other dislocation of finger
S63.19	Unspecified dislocation of finger
S63.2	Multiple dislocations of fingers
S63.3	Traumatic rupture of ligament of wrist and carpus
S63.4	Traumatic rupture of ligament of finger at metacarpophalangeal and interphalangeal joint(s)
S63.50	Sprain and strain of carpal (joint) of wrist
S63.51	Sprain and strain of radiocarpal (joint)(ligament) of wrist
S63.58	Other sprain and strain of wrist
S63.59	Unspecified sprain and strain of wrist
S63.60	Sprain and strain of interphalangeal (joint) of finger(s)
S63.61	Sprain and strain of metacarpophalangeal (joint) of finger(s)

S63.68	Other sprain and strain of finger(s)
S63.69	Unspecified sprain and strain of finger(s)
S63.70	Sprain and strain of carpometacarpal (joint) of hand
S63.71	Sprain and strain of metacarpal (distal) (proximal)
S63.72	Midcarpal sprain and strain of hand
S63.78	Sprain and strain of other parts of hand
S63.79	Sprain and strain of unspecified parts of hand

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF HIP

CODE	INJURY DESCRIPTION
S73.00	Posterior dislocation of hip
S73.01	Obturator dislocation of hip
S73.08	Other anterior dislocation of hip
S73.09	Unspecified dislocation of hip
S73.10	Sprain and strain of iliofemoral ligament
S73.11	Sprain and strain of ischiocapsular ligament
S73.18	Sprain and strain of other specified sites of hip
S73.19	Sprain and strain of unspecified site of hip

DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF KNEE

CODE	INJURY DESCRIPTION
S83.0	Dislocation of patella
S83.10	Anterior dislocation of knee
S83.11	Posterior dislocation of knee
S83.12	Medial dislocation of knee
S83.13	Lateral dislocation of knee
S83.18	Other dislocation of knee
S83.19	Unspecified dislocation of knee
S83.20	Tear of medial cartilage or meniscus of knee, current
S83.21	Tear of lateral cartilage or meniscus of knee, current
S83.3	Tear of articular cartilage of knee, current
S83.400	Sprain and strain of lateral collateral ligament of knee, rupture
S83.401	Other sprain and strain of lateral collateral ligament of knee
S83.410	Sprain and strain of medial collateral ligament of knee, rupture
S83.411	Other sprain and strain of medial collateral ligament of knee
S83.480	Sprain and strain of other collateral ligament of knee, rupture
S83.481	Other sprain and strain of other collateral ligament of knee
S83.490	Sprain and strain of unspecified collateral ligament of knee, rupture
S83.491	Other sprain and strain of unspecified collateral ligament of knee
S83.500	Sprain and strain of anterior cruciate ligament of knee, rupture
S83.501	Other sprain and strain of anterior cruciate ligament of knee
S83.510	Sprain and strain of posterior cruciate ligament of knee, rupture

S83.511	Other sprain and strain of posterior cruciate ligament of knee
S83.580	Sprain and strain of other cruciate ligaments of knee, rupture
S83.581	Other sprain and strain of other cruciate ligaments of knee
S83.590	Sprain and strain of unspecified cruciate ligament of knee, rupture
S83.591	Other sprain and strain of unspecified cruciate ligament of knee
S83.6	Sprain and strain of other and unspecified parts of knee
S83.7	Injury to multiple structures of knee

Patient Information Examples

Patient Check List for Whiplash-Associated Disorders (example # 1)

This data check list is intended as a guide to the assessment and treatment of a whiplash patient with Grade I or Grade II WAD injuries. The checklist is not an exhaustive list and does not take into consideration any non-WAD injuries.

History (PATIENT/CLAIMANT TO COMPLETE)

1. Symptom Checklist

For each symptom, check YES (if present) or NO (if not present), and rate severity on a scale of 0 to 10 where indicated 0 is "No Pain" and 10 is "pain as bad as it could be."

Neck or shoulder pain ☐YES ☐NO

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as Bad as Could Be

Upper or Mid-back pain ☐YES ☐NO

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as Bad as Could Be

Low back pain ☐YES ☐NO

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as Bad as Could Be

Headache ☐YES ☐NO

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as Bad as Could Be

Pain in Arm(s) ☐YES ☐NO

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as Bad as Could Be

Pain in Hand(s) ☐YES ☐NO

No Pain — Pain as Bad as Could Be

0 1 2 3 4 5 6 7 8 9 10

Pain in Face or Jaw ☐YES ☐NO

No Pain — Pain as Bad as Could Be

0 1 2 3 4 5 6 7 8 9 10

Pain in Leg(s) ☐YES ☐NO

No Pain — Pain as Bad as Could Be

0 1 2 3 4 5 6 7 8 9 10

Pain in Foot/Feet ☐YES ☐NO

No Pain — Pain as Bad as Could Be

0 1 2 3 4 5 6 7 8 9 10

Pain in Abdomen or Chest ☐YES ☐NO

No Pain — Pain as Bad as Could Be

0 1 2 3 4 5 6 7 8 9 10

Feeling of numbness, tingling in arms or hands ☐YES ☐NO

Feeling of numbness, tingling in legs or feet ☐YES ☐NO

Dizziness or unsteadiness ☐YES ☐NO

Vision problems ☐YES ☐NO

Hearing problems ☐YES ☐NO

Anxiety or worry ☐YES ☐NO

Nausea or vomiting ☐YES ☐NO

Difficulty swallowing ☐YES ☐NO

Problems concentrating or with memory ☐YES ☐NO

2. ***Loss of consciousness*** ☐YES ☐NO

3. ***Have the injuries prevented you from carrying out any of the following:***

   ☐ Daily home activities (Ask patient/claimant to explain)
   ☐ Employment (Ask patient/claimant to explain)
   ☐ Schooling (Ask patient/claimant to explain)
   ☐ Sports or recreation
   ☐ Other (Ask patient/claimant to explain)

4. ***Do you think your injury will:***

   ☐ get better soon
   ☐ get better slowly
   ☐ never get better
   ☐ don't know

Patient Education (Example # 2)

One of the key aspects of the DTPR is the emphasis on patient education. The following is an example of the kind of information and education you could provide to a patient with a grade I or II WAD injury when appropriate.

To the patient:

1. On the basis of your symptoms and the examination, you have grade I (or II) WAD. This means most likely that you have a sprain of muscles and/or ligaments and that you do not have a fracture, injury to nerves, or other serious damage that we can detect.

2. The symptoms you are experiencing are normal and common for your type of injury. Additional physical and psychological conditions or symptoms may also arise from the WAD injury, and typically resolve with the injury. Most people recover from this injury within 6 weeks, and you should have no long term problems.

3. It is rare that people have chronic pain and trouble working or enjoying their usual lifestyle after the injury. There are things you can do to help reduce the chance of this happening. And there are other things you may do that will increase the chance of chronic pain happening. As long as you focus on what you can do to recover, you will do well.

4. It is important to maintain normal activities or modified activities as much as possible. At first, these activities might be painful, but evidence suggests that resuming normal activities will help improve your recovery. There is no evidence that normal activities, even though they may hurt, will cause any long-term harm.

5. Start with exercise and good posture maintenance early. Whiplash patients/patients who exercise daily despite the fact that these exercises may hurt initially do better than those who rest and hope the pain will go away on its own.

6. Avoid using a collar. While collars may offer temporary relief, using a collar actually prolongs recovery.

7. Avoid relying solely on non-exercise (passive) therapies. In general, whiplash patients/patients who use these types of passive therapies instead of exercise, or people who have an expectation that others will cure them, do not do well. The best approach with the best chance of recovery is to exercise daily.

8. Do not rely on medications to completely eliminate pain. There is no evidence that medications speed recovery from whiplash injury. Medications may help in the short term if they ease the pain and allow people to keep active and exercise regularly. Over- the-counter medications are known to be the safest and should be used first. Other pain killers and medications cause many side effects including sedation, dizziness, dry mouth, poor concentration, and poor memory, ringing in the ears, visual disturbance, and headache.

9. Although it may be difficult, paying too close attention and continually worrying about the symptoms will, in fact, make the symptoms more severe. The same is true for talking with friends and family members about the amount of pain. The best approach is to try to relax, carry on with normal

activities, exercise appropriately and understand that it might take some time, but the pain will go away.

10. Aches and pains, headaches and many other symptoms are common in life, especially if life becomes stressed. Don't necessarily assume that problems noticed months later are caused by the injury. It is natural for people to pay closer attention to their bodies after an injury. The best distraction from pain and the natural tendency to pay more attention to symptoms is to continue normal, everyday activities despite the hurt, keep a regular schedule, and keep stress levels down.

Appendix G — Claims and Billing Information

General Claims Information

Alberta residents who are an occupant of a vehicle involved in a motor vehicle accident have accident benefits insurance coverage regardless of whether they were at fault for the collision. To claim these benefits, the patient will require the assistance of their insurance adjuster and a primary health care practitioner.

This section outlines the administrative process for the patient/patient, primary health care practitioners and insurers. The claims process is designed to provide a streamlined, step-by-step approach where one step flows smoothly to the next and the patient gets the continuity of service and treatment they need, consistent with the DTPR when applicable. As part of the process, primary health care practitioners will be compensated for completing the necessary claim forms.

If a patient is being treated outside the DTPR a chiropractor or physiotherapist shall bill the patient unless authorized by the insurance company.

Under the DTPR, all patients may receive up to a maximum of 10 or 21 pre-authorized payments for treatment visits, depending on the type of injury.

A primary health care practitioner indicating on the Treatment Plan AB-2 form that the patient can be treated with fewer visits does not prevent the patient from receiving the full 10 or 21 treatments (based on the type of injury), when required.

Physician visits are covered by the Alberta Health Care Insurance and are not included in:

- the 10 or 21 treatments based on the type of injury, or
- the number of assessments available to the patient.

It is important to remember that, should the aforementioned number of treatment visits be insufficient to address a patient's injury, they can still claim treatment visits covered under other plans. For many patients coverage is available under extended health benefits (e.g., Blue Cross or similar employee benefit plans with health spending accounts), under Section B of the Automobile Accident Insurance Benefits Regulations, or from the patient's automobile insurer under Section B of the Standard Automobile Policy (SPF #1).

Treatments that are within a primary health care practitioner's scope of practice are subject to that primary health care practitioner's regulated fee schedule. This includes any treatment authorized by the DTPR that the primary health care practitioner provides himself or herself

If you have any questions, please contact either the claims adjuster, the insurer's claims manager or the insurer's ombudsperson for your patient/patient. If you are having difficulty contacting the claims adjuster for your patient please refer to the Government of Alberta website at: http://insurance.alberta.ca.

Claims Timelines and Responsibilities

Timelines	Responsibilities
0 to 10 business days following the collision	Assess and diagnose the patient according to the DTPR, if applicable. Assist the patient in completing the Notice of Loss and Proof of Claim Form (Form AB-1). This form must be completed by patients and submitted to the insurer within 10 business days of the collision or as soon as practicable. The practitioner providing ongoing treatment of the patient should complete the Treatment Plan (Form AB-2). Physicians should not complete the AB-2 form unless they are treating a patient, or choose to actively coordinate the care and treatment visits of the patient. If the injury includes a sprain, strain or WAD (I or II). Although no referral or approval is required, if necessary, inform the insurer (Form AB-2) that you may require authorization to use goods and services not included in the DTPR (i.e., psychological care, occupational therapy, nursing, dental care). If it is likely that the patient will be disabled for a period of time and is likely to lose income, the patient may ask a primary health care practitioner to assist them to complete a claim for disability benefits (Form AB-1a).
Within 5 business days after the Notice of Loss and Proof of Claim Form (Form AB-1) has been submitted (5 – 15 days following the collision)	Contact the insurer to confirm approval of the claim and obtain contact information of the insurance claims adjuster. If the claim is approved, continue to educate and reassure the patient and provide treatment within limits of the DTPR. Although claims can only be denied in limited circumstances, if the claim is refused the claims representative will honour treatment expenses incurred to the point of refusal.

Timelines	Responsibilities
5 to 21 days post-collision	For WAD I or WAD II patients/patients, seek to reassess the patient within 21 days if any alerting factors were present at the initial examination. If the injury is not resolving, a primary health care practitioner may authorize a visit by the patient to an Injury Management Consultant for an assessment and report.
15 to 90 days post-collision and before completion of 10 or 21 treatments	Maintain contact with insurer regarding the patient/patient's progress if requested by the insurer. Provide progress and discharge reports as appropriate to the insurer by completing forms AB-3 (which is required only at the request of the insurer) and AB-4 (which is mandatory whether or not requested by the insurer). Prior to completion of treatments, notify the claims representative of the need for either additional services or a referral to an Injury Management Consultant if the patient/patient's injury is not resolving satisfactorily. A copy of the referral form (Form AB-5) should be provided to the insurer and the IMC. If the patient has recovered, submit final invoice and submit a discharge report (Form AB-4).
15 to 90 days post-collision and upon completion of treatments	If the patient has recovered, submit final invoice and submit a discharge report (Form AB-4). If the patient has not recovered, notify the insurer of payments for further services (Forms AB-3 or AB-4 could be used as applicable). Refer patient to Injury Management Consultant (A copy of the referral form (Form AB-5) should be provided to the insurer with an explanation of the need for referral). **Note: Authorization for payment under the DTPR expires 90 days after the motor vehicle accident unless the insurer approves use of the DTPR beyond 90 days**

Claims for Injuries within the DTPR

It is important to remember the following:

Fees and Payment for Services

- Payments
  - Bill the insurer directly for all treatment services described in the DTPR that are not covered by Alberta Health Care Insurance.
  - Payments by insurers for services provided under the DTPR must be within 30 days of receipt of the invoice.
  - Authorization for payment under the DTPR expires 90 days after the collision unless the insurer approves use of the DTPR beyond 90 days.
  - Payment for a report may not be honored if documents are incomplete or illegible.
- Charging for treatment visits
  - With respect to primary health care practitioner fees for patient treatment visits, fees will be applied according to how many treatment visits **with all primary health care practitioners** a patient has already attended.
  - A primary health care practitioner may charge the prescribed fee for the following treatment visits:
    - If the patient has a maximum of 10 preauthorized injury treatments, the 1st to 3rd visit (including all other permitted practitioner visits attended); or
    - If the patient has a maximum of 21 preauthorized injury treatments, the 1st to 7th visit (including all other permitted practitioner visits attended).
    - All additional visits with permitted primary health care practitioners have a separate prescribed fee.
- If a patient misses an appointment or is late for an appointment, the insurer is not responsible under the DTPR for reimbursing the primary health care practitioner or adjunct therapy practitioner for that time. The primary health care practitioner or adjunct therapy practitioner may charge the patient a late or missed appointment fee in accordance with any directive from the respective college or association.

Invoicing and Forms

- Submit the applicable **completed** form (AB-1, AB-2, AB-3 or AB-4) and current invoice statements of your office.
  - The Notice of Loss and Proof of Claim Form (Form AB-1) must be completed by a patient and submitted to the insurer within 10 business days of the collision or as soon as practicable.

  - Practitioners are responsible to have an internal administrative process to verify the services provided to patients.

- The insurer is not required to pay expenses until the Notice of Loss and Proof of Claim Form (Form AB-1) has been received by the insurer.

  - If Form AB-1 cannot practicably be submitted within 30 days of the accident, the patient or their representative should contact the insurer.

- When generating the final invoice to the insurer, a copy of the invoice shall be mailed to the patient with a standard letter that indicates the following: "Your insurer has been billed in the amounts shown for all goods and services listed. Please review the invoice and report any errors to the signatory or your insurer."

Accident Benefits and Additional Treatments

- The DTPR is intended to cover services provided by primary health care practitioners and adjunct therapy practitioners (for example, massage therapists and acupuncturists). The provision of other services listed under Section B – Accident Benefits of the Automobile Accident Insurance Benefits Regulation (such as dental services, psychological services, occupational therapy, etc.) to the patient is permitted to occur simultaneously. The provision of these services does not cancel preauthorization of services under the DTPR by primary health care practitioners and adjunct therapy practitioner.

- Adjunct therapies will only be preauthorized when directed by a primary health care practitioner, which is documented on the Treatment Plan AB-2 form. If adjunct therapies have not been preauthorized under the DTPR, patients can still seek to obtain those services under Accident Benefits of the Automobile Accident Insurance Benefits Regulation (Section B).

- If you or your patient believes that additional treatment is required or if you are uncertain about a patient's diagnosis, the patient can be referred to an IMC (Form AB-5). The purpose of a referral to an IMC is twofold: to establish or confirm a diagnosis and/or to provide recommendations on the best treatment options to facilitate recovery.

- During the period in which the diagnostic and treatment DTPR apply, insurers are not authorized to request a medical assessment with respect to: any service, diagnostic imaging, laboratory testing, specialized testing, supply, treatment, visit, therapy, assessment, making a report or other activity or function authorized under the DTPR. However, if a patient or a health provider is seeking diagnostic and treatment services that are not covered by the DTPR or once the DTPR period has ended, the insurer is able to request a medical assessment with respect to those services.

Additional Information and Support

- For help locating or contacting a claims adjuster, please contact the Insurance Bureau of Canada by telephone at 1-800-377-6378.

- Further information related to the establishment of fees, form amendments and related issues shall be forwarded to your respective professional associations and published in an interpretation bulletin at: http://insurance.alberta.ca.

Claims for Injuries outside the DTPR

Under Section B, an Insurer must pay reasonable expenses incurred within 2 years from date of accident for necessary medical, surgical, chiropractic, dental, hospital, psychological, physical therapy, occupational therapy, massage therapy, acupuncture, professional nursing and ambulance services and, in addition, other services and supplies that are, in the opinion of the insured person's attending physician and in the opinion of the insurer's medical advisor, essential for the treatment or rehabilitation of the insured person, to the limit of $50,000.

- If a patient, or a primary health care provider, is seeking diagnostic and treatment services that are not covered by the DTPR or once the DTPR period has ended, the insurer is able to request a medical assessment with respect to those services.

- If a patient has an injury not covered by the DTPR, the insurer has no right and the patient is under no obligation to undergo a medical assessment for the following services:

    - Chiropractic services (up to $750 per person);

    - Massage therapy services (up to $250 per person);

    - Acupuncture services (up to $250 per person);

    - Psychological services (up to $600 per person);

    - Physical therapy services (up to $600 per person); and

    - Occupational therapy services (up to $600 per person).

        - These amounts are in addition to services provided for under the DTPR and Alberta Health Care Insurance.

- Primary health care practitioners need to be aware that, outside the DTPR, the priority of payment rule is different from inside the DTPR. Under the DTPR, an insurer is the first payer after Alberta Health Care Insurance. Outside the DTPR, an insurer is the second payer after both extended health benefits (e.g. Blue Cross or similar employee benefit plans with health spending accounts) and Alberta Health Care Insurance.

Related services, inside and outside the DTPR

Section B, Alberta Health Care Insurance, and a patient are each responsible for compensating the primary health care practitioner and other health service providers for certain services and supplies.

- If the patient is being treated within the DTPR, the primary health care practitioner may invoice the insurance company directly for necessary supplies and services (e.g., exercise balls, tensor bandages, etc.).

- If an expense is paid out of pocket by a patient, he or she can claim for reimbursement from an insurer.

- Treatment visits under the DTPR are intended to be free of any financial and administrative barriers that might limit patients seeking early, appropriate treatment for their injuries.

    - "Extra" (or balance) billing practices pose a financial barrier as well as stress to a patient, therefore practitioners may not extra-bill. This prohibition is set out in section 5(1) of the DTPR and interpretation bulletin at: http://insurance.alberta.ca.

- This provision is not intended to cover a primary health care practitioner's overhead expenses or in-clinic consumption items. Items are eligible to be claimed provided that they are itemized on the invoice, they assist the patient with necessary self-care, and they are reasonably priced. These are supplies that a patient would utilize, usually in the home, such as exercise balls and tensor bandages.

The table below is a summary of which party will initially be expected to provide payment for specific services:

Service Provided	Individual or Plan to be Billed		
	Insurer	Patient / Claimant	Alberta Health Care Insurance
1. Initial Assessment of the Patient/Claimant and Completion of Form AB-1			
Assessment by Medical Doctor	X		X
Assessment by Chiropractor or Physical Therapist	X		
2. Completion of Treatment Plan (Form AB-2)			
Assessment by Chiropractor or Physical Therapist, if Form	X		
Completion of the Treatment Plan	X		
3. Fee for completion of the Progress Report or Concluding Report			
Completion of Progress Report (Form AB-3)	X		
Completion of the Concluding Report (Form AB-4)	X		
4. Completion of the IMC Referral Form			
Completion of the IMC Referral Form	X		
5. Disability Assessment and Completion of Form (AB-1a)			
Assessment by Registered Physician			X
Completion of Claim for Disability Benefits (Form AB-1a)		X (Reimbursed by Insurer)	
6. Missed or Late Appointment			
Missed or Late Appointment		X	
7. Necessary Supplies or Services			
Supplies to assist rehabilitation (e.g. exercise balls, tensor bandages, cold packs, etc.). Approval required from Insurer if total expected to be $160 for WAD II or third degree sprain or strain, $120 for WAD I, $60 first or second degree sprain or strain, or $160 for all sprains, strains, and WAD I and II injuries.	X (Inside Protocols)	X (Outside Protocols)	

Prescribed Forms

The Alberta Accident Benefits Claims Forms can be found in fillable PDF format on the Government of Alberta's website at: http://insurance.alberta.ca in the "Forms" section.

1. **Initial assessment of a patient and Notice of Loss and Proof of Claim Form (Form AB-1)**

   Assessment

   - A patient requiring an initial assessment of his or her injury can choose to be assessed by either a medical doctor, physical therapist or chiropractor in accordance with section 9(1)(a), 13(1)(a), 18(1)(a), 21(a), 22(1)(a) and 23 of the DTPR.

   Completion of Form

   - The AB-1 form should be completed by a patient or, if required, by his or her designate. A patient or his or her designate can obtain the form from the insurer. Primary health care practitioners should **not** complete or submit the AB-1 form. There is no fee for completing this form.

   Invoicing and Payment for Services

   - A medical doctor shall invoice Alberta Health Care Insurance for the assessment.
   - A chiropractor or a physical therapist shall invoice the insurer for the assessment.
   - In an initial assessment, if a medical doctor recommends a patient be further treated by a physical therapist or chiropractor, the subsequent treating physical therapist or chiropractor is entitled to an initial assessment fee and a completion of treatment plan fee to be paid by the insurer.
   - Pursuant to Section 24(2) and 22(1)(a) of the DTPR, a physical therapist or a chiropractor is not entitled to a fee for the second assessment of the patient's injury without the approval of the insurer, including the reassessment within 21 days or referral to an IMC if the patient exhibited any alerting factors. However, a medical doctor may apply to Alberta Health Care Insurance for reimbursement of the services he or she has provided under the schedule of medical benefits.

2. **Treatment Plan Form (Form AB-2)**

   Completion of Form

   - The AB-2 form is to be completed by the primary health care practitioner who will be actively engaged in the assessment and continuing care of the patient. In most cases, this will be a physical therapist or a chiropractor.
   - Primary health care practitioners are reminded that the AB-2 form should be completed and submitted to the insurer within ten (10) business days of the first assessment of the patient.

Copies of the AB-2 form should be provided to insurers and the primary health care practitioners providing treatment, as well as to the patient.

- The insurer is not obliged to pay for the form until it has been fully and correctly completed.

Invoicing and Payment for Services

- The form shall be sent directly to the insurer for payment. The insurer is not obliged to pay for the form until it has been fully and correctly completed. If a physical therapist or chiropractor has invoiced the insurer for an initial assessment and completion of Form AB-2, they are not entitled to invoice the insurer for a second assessment.

- Where a primary health care practitioner has taken and documented that action (e.g., contacting the insurer), and the insurer advises that no other Treatment Plan AB-2 form has been submitted or is anticipated, then invoices for the assessment, completing the AB-2 form, and providing treatment will be honored by the insurer. If the insurer has been notified and failed to respond to the primary health care practitioner, payment for the services provided will be paid. The patient shall confirm the name of their primary health care practitioner with his or her insurer.

- The primary health care practitioner (who completes the AB-2 form and is actively coordinating the care and treatment visits of the patient) must be explicit as to the treatment method(s), as only the treatment prescribed on the AB-2 form is pre-authorized for payment.

Switching Primary Health Care Practitioners and Referrals

- A patient may have gone to more than one primary health care practitioner for assessment and treatment of their injury. **The primary health care practitioner should ask the patient if he or she has contacted other primary health care practitioners about the injury, document the actions taken, and contact the insurer prior to attending the patient.**

- If a patient wishes to switch primary health care practitioners or deviate from the treatment plan they should discuss this with the relevant primary health care practitioners and their insurer.

- Where a patient chooses to engage another primary health care practitioner after the initial assessment and completion of the Treatment Plan AB-2 form, the “new” primary health care practitioner may bill the patient directly for their assessment and completion of the AB-2 form. This amount is not recoverable from the insurer under Section B.

- If a primary health care practitioner refers a patient for treatment, it is important for the referring practitioners to advise whether or not they have completed the AB-2 form. They should provide a copy to the other practitioners for their reference if one is completed.

3. Progress Report (Form AB-3)

Completion of Form

- The form will be sent from the insurer to the primary health care practitioner.
- The insurer is not obliged to pay for the form until it has been fully and correctly completed. The primary health care practitioner shall bill the insurer directly.

Invoicing and Payment for Services

- The primary health care practitioner is entitled to invoice the insurer for the cost of completing these reports only if the insurer requests additional information about the patient's progress.

4. Completion of the Concluding Report (Form AB-4)

Completion of Form

- This form should be completed by the primary health care practitioner, which may not be the practitioner who completed the AB-2 form, who provided the majority of treatment visits at the conclusion of treatment visits.
- **This form is mandatory for all cases being treated under the DTPR when a Treatment Plan AB-2 form has been completed.**
- The insurer is not obliged to pay for the form until it has been fully and correctly completed.

Invoicing and Payment for Services

- The primary health care practitioner shall send this form to the insurer with the last invoice for treatments authorized by the DTPR. A copy of the last invoice shall also be sent to the patient with an information letter.

5. Referral Form to an Injury Management Consultant (Form AB-5)

Referrals to an IMC

- The primary health care practitioner **does not** require authorization from the insurer to refer a patient to an Injury Management Consultant. However, as a best practice, a primary health care practitioner considering a patient referral to the Injury Management Consultant should notify the insurer of his or her intent whenever possible.

Completion of Form

- This form must be completed by the primary health care practitioner who established the working diagnosis.
- The insurer is not obliged to pay for the form until it has been fully and correctly completed.

Invoicing and Payment for Services – Primary Health Care Practitioners

- Pursuant to sections 24 and 25 of the DTPR, a primary health care practitioner may refer a patient to an IMC. Upon receipt of the completed referral form (Form AB-5), the insurer will compensate the primary health care practitioner for this service.

- The primary health care practitioner shall bill the insurer directly.

- A primary health care practitioner may not invoice the insurer for a referral to another primary health care practitioner or adjunct therapy practitioner.

Invoicing and Payment for Services – IMC

- The invoice for an IMC's opinion which includes the cost of the report shall be sent directly to the insurer. The IMC is required to issue a report and copy both the insurer and the primary health care practitioner. Upon receipt of the report, the insurer will compensate the IMC for this service.

- If the IMC requests additional information, the primary health care practitioner may charge a base rate plus fee per page to the insurer. After 90 days from the date of a collision, an invoice can be sent to the insurer only if the insurer has approved the assessment by the IMC.

6. Disability assessment and Claim for Disability Benefits (Form AB-1a)

Completion of Form

- This form is to be completed **only** by physicians, at the request of the insurer.

Invoicing and Payment for Services

- A medical doctor shall invoice Alberta Health Care Insurance for the assessment and the patient or his or her insurer for completion of Form AB-1 a.

7. Missed or late appointments

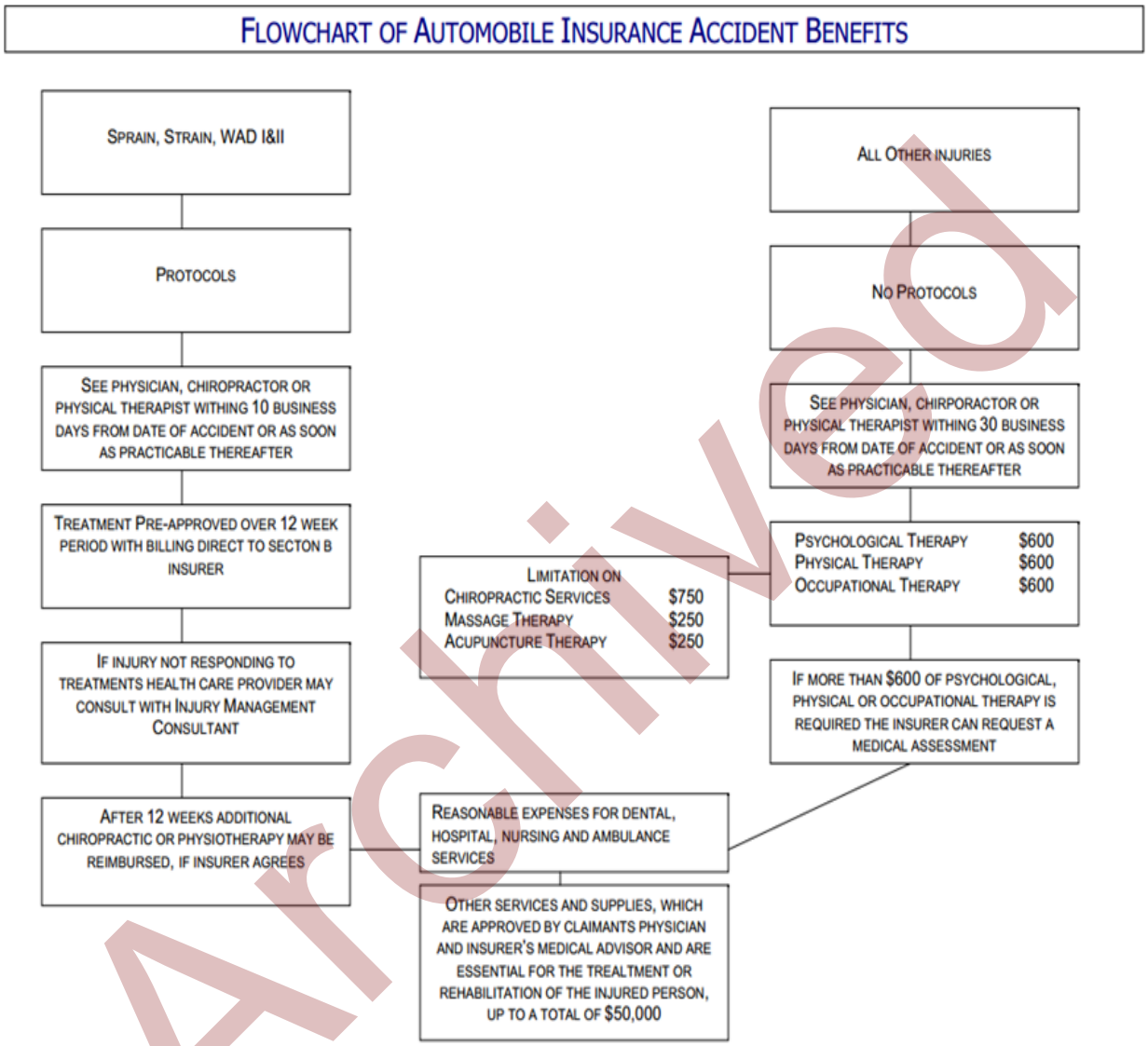
- If a patient misses an appointment or is late for an appointment, the insurer is not responsible for reimbursing the primary health care practitioner for that time. The primary health care practitioner may charge the patient a late or missed appointment fee.

8. Health Records

- If full or partial copies of health records of the patient are required, the amount shall not exceed the amount established by the Health Information Regulation pursuant to the *Health Information Act.*

9. Necessary supplies and services

- Necessary medical supplies must meet the following criteria:
  - Itemized on the invoice;
  - Assist with self-care;
  - Reasonably priced;
  - Prohibit financial barriers for the patient;
  - Used in the home by the patient; and
  - Is not part of the primary health care practitioner's overhead expenses or in-clinic consumption items.
- There is no differentiation between supplies used in passive vs. active modalities of care.
- There is no exhaustive list of approved medical supplies due to continuous medical advancements.
- If the patient is being treated within the DTPR, the primary health care practitioner may invoice the insurer directly for these supplies. Outside the DTPR, the primary health care practitioner shall bill the patient unless some alternative arrangement has been agreed to by the insurer.
- If diagnostic imaging services are required, the amount payable shall not exceed the amount set out in the Schedule of Medical Benefits pursuant to the *Alberta Health Care Insurance Act*. The Schedule of Medical Benefits can be found at: www.health.alberta.ca/professionals/somb.html.
- The primary health care practitioner shall first obtain approval from the insurer for reimbursement of these supplies (excluding medications) if the total is expected to be greater than:
  - $160 for WAD II and third degree sprain or strain injuries;
  - $120 for WAD I injuries;
  - $60 for first and second degree sprain or strain injuries; or
  - $160 for all sprains, strains and WAD I or II injuries.


FLOWCHART OF AUTOMOBILE INSURANCE ACCIDENT BENEFITS
SPRAIN, STRAIN, WAD I&II
PROTOCOLS
SEE PHYSICIAN, CHIROPRACTOR OR PHYSICAL THERAPIST WITHING 10 BUSINESS DAYS FROM DATE OF ACCIDENT OR AS SOON AS PRACTICABLE THEREAFTER
TREATMENT PRE-APPROVED OVER 12 WEEK PERIOD WITH BILLING DIRECT TO SECTON B INSURER
IF INJURY NOT RESPONDING TO TREATMENTS HEALTH CARE PROVIDER MAY CONSULT WITH INJURY MANAGEMENT CONSULTANT
AFTER 12 WEEKS ADDITIONAL CHIROPRACTIC OR PHYSIOTHERAPY MAY BE REIMBURSED, IF INSURER AGREES
LIMITATION ON
CHIROPRACTIC SERVICES $750
MASSAGE THERAPY $250
ACUPUNCTURE THERAPY $250
REASONABLE EXPENSES FOR DENTAL, HOSPITAL, NURSING AND AMBULANCE SERVICES
OTHER SERVICES AND SUPPLIES, WHICH ARE APPROVED BY CLAIMANTS PHYSICIAN AND INSURER'S MEDICAL ADVISOR AND ARE ESSENTIAL FOR THE TREALTMENT OR REHABILITATION OF THE INJURED PERSON, UP TO A TOTAL OF $50,000
ALL OTHER INJURIES
NO PROTOCOLS
SEE PHYSICIAN, CHIRPORACTOR OR PHYSICAL THERAPIST WITHING 30 BUSINESS DAYS FROM DATE OF ACCIDENT OR AS SOON AS PRACTICABLE THEREAFTER
PSYCHOLOGICAL THERAPY $600
PHYSICAL THERAPY $600
OCCUPATIONAL THERAPY $600
IF MORE THAN $600 OF PSYCHOLOGICAL, PHYSICAL OR OCCUPATIONAL THERAPY IS REQUIRED THE INSURER CAN REQUEST A MEDICAL ASSESSMENT

Appendix H – Recommended Guidelines: Injury Management Consultant Report

If the time taken by an Injury Management Consultant to complete all aspects of this service, including an assessment, is expected to exceed or exceeds one-hour, the chiropractor or physiotherapist may seek authorization to spend additional time from the appropriate insurance company. This amount includes fees for up to one-hour of an Injury Management Consultant's time.

Statement of the purpose for the examination and relevant issues.

1. Review of relevant information from the primary health care practitioner.
2. Relevant history of the injury including:
    - Mechanism of injury;
    - Previous history of injury to the same part of the body; and
    - Progress of recovery that includes review of consultation(s), investigation(s), and treatment, as well as response to treatment.
3. Relevant medical history – physical, psychological, emotional, cognitive, and surgical history.
4. Current status of patient, including present complaints.
5. Details of examination including:
    - General;
    - Regional;
    - Musculoskeletal;
    - Neurological; or
    - Any functional limitations.
6. Any further investigation and assessment carried out.
7. Diagnosis and prognosis.
8. Recommended treatment or further assessment.